FIFTH JUDICIAL DISTRICT COURT
COUNTY OF EDDY
STATE OF NEW MEXICO

MARY ANN MULLINS,

Plaintiff,

VS.

NO. D-503-CV-2017-00428

Case assigned to Romero, Raymond L.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant

COMPLAINT FOR PAYMENT OF LIFE INSURANCE PROCEEDS TO BENEFICIARY

Comes Now Plaintiff and states:

1. Plaintiff is resident of Eddy County, New Mexico and beneficiary of life insurance policy issued by Defendant Metropolitan Life Insurance Company, hereinafter referred to as MetLife upon the life of Royce Allen.

2. MetLife is an insurance company doing business in Eddy County, New Mexico.

3. That Plaintiff and Royce Allen, deceased, lived together, although not married, for 15 years. That Plaintiff and Royce Allen were employed with Nuclear Waste Partnership, LLC for number of years with Royce Allen, deceased maintaining life insurance coverage with Defendant MetLife during his employment. At all times material hereto, Plaintiff Mullins was designated beneficiary of said life insurance policy issued by Defendant MetLife.

4. That in early 2015, Royce Allen was diagnosed with Stage 4 cancer and as a result of such illness, Royce Allen was placed on Short Term Disability under group plan of Nuclear

EXHIBIT
A

Waste Partnership. That said Short Term Disability provided for coverage to Royce Allen for 180 days with Royce Allen to be placed on Long Term Disability plan upon expiration of 180 days period.

5. That upon expiration of term of Short Term Disability on or about September 2, 2015. said Royce Allen transferred to Long Term Disability plan. That under the terms of Long Term Disability plan, life insurance coverage as existed for Royce Allen under benefit program as employee could not continue with Royce Allen being permitted to convert group insurance policy coverage to an individual policy with Defendant MetLife. That Royce Allen duly completed conversion documents for individual policy as provided with terms of Long Term Disability. That included in such conversion procedures, Royce Allen completed Group Term Life Insurance Beneficiary Designation form naming Plaintiff as beneficiary of life insurance policy upon life of Royce Allen with such Designation dated 2 September, 2015. Copy of Beneficiary Designation is attached and incorporated herein as Exhibit "A". That said Royce Allen further executed forms required for Long Term disability forms required by Defendant MetLife for conversion of Group Life Insurance policy to individual insurance policy with copy of said conversion documents being attached as Exhibit "B"

6. That thereafter on September 15, 2015, Royce Allen was hospitalized in Lubbock, Texas where he remained until his death on October 26, 2015. That with such hospitalization, Royce Allen was incapable of movement due to medical procedures. That in mid October, Plaintiff requested confirmation of insurance benefits and long term disability benefits for benefit of Royce Allen through Plan Administrator of Nuclear Waste Partnership with Defendant MetLife. That Defendant MetLife confirmed said benefits for Royce Allen to said Plan Administrator.

7. That thereafter, Defendant MetLife requested execution of insurance application involved in the conversion of life insurance policy. That said application was provided to Plan Administrator and forwarded to Plaintiff who was in Lubbock, Texas with Royce Allen. That due to the incapacity of Royce Allen due to medical treatments, Plaintiff completed application documents and forwarded the same to Defendant MetLife. Copy of Application documents are attached and incorporated herein as Exhibit "C".

8. That Defendant MetLife collected premiums for life insurance conversion policy from bank account of Plaintiff and Royce Allen for months of September and October, 2015 and thereafter charged one further monthly premium to account of Plaintiff and Royce Allen. That in addition thereto, Defendant MetLife advised personnel of Nuclear Waste Partnership of completion of conversion of life insurance policy and coverage of Royce Allen.

9. That thereafter, Defendant MetLife refused to honor obligation under Life Insurance policy for Royce Allen and has refused to pay to Plaintiff all sums as provided in Life Insurance contract.

COUNT I

10. Plaintiff adopts and incorporates allegations contained in Paragraphs 1-9 herein.

11. That Defendant MetLife has breached its obligations of payment benefits due Plaintiff under terms and provisions of Life Insurance policy issued by Defendant..

12. That Plaintiff has made due and proper application for benefits under said life insurance policy with said application being denied by Defendant.

13. That under the facts and circumstances in the matter herein, Defendant MetLife is estopped to deny coverage for life insurance benefits due Plaintiff.

14. That Plaintiff is entitled to recover interest upon proceeds of life insurance benefits wrongfully refused by Defendant.

WHEREFORE, Plaintiff prays Judgment against Defendant for proceeds of life insurance policy covering Royce Allen, deceased; for interest upon all sums owing by Defendant; for pre-judgment interest; for recovery of her costs and for such other and further relief as the Court may deem equitable.

COUNT 2

15. Plaintiff adopts and incorporates the allegations contained in Paragraphs 1-14 herein.

16. That denial of payment of proceeds of life insurance policy issued by Defendant on life of Royce Allen under the facts of the matter herein is a unfair claim practice under provisions of Section 59A-16-20 (E).

17. That Plaintiff is entitled to recover proceeds of life insurance contract on life of Royce Allen and for interest thereon along with reasonable attorney fees incurred in the proceeding herein.

WHEREFORE, Plaintiff prays Judgment against Defendant for all sums determined by the trier of fact; for interest on all said sums; for pre-judgment interest, for her costs and reasonable attorney fees incurred in the proceeding herein.

TEMPLEMAN AND CRUTCHFIELD
113 E. Washington
Lovington, New Mexico 88260

By: _____

MetLife

Group Term Life Insurance Beneficiary Designation

- This form MUST be signed before you return it. See "SECTION IV – Signature" on page 3.

SECTION I - Insured Information

Customer Number		Employer Name/Group Policyholder Name
First Name ROYCE	Middle Name E	Last Name ALLEN
Address – Street 904 WELEKA LN.	City CARLSBAD	State NM ZIP Code 88220
Date of Birth [redacted]	Phone Number (575) 706-1736	SSN [redacted]

SECTION II - Plan Information

I elect that the beneficiary designation shown on this form apply only to the plans insured by MetLife that I have indicated below:

☐ All group term life coverage currently in effect OR ☐ Basic Life ☐ Accidental Death & Dismemberment ☑ Supplemental/Optional Life CONSULTORED

SECTION III - Beneficiary Information

- You MUST designate at least one primary beneficiary. A person may only be listed once. Anyone listed in the primary section cannot be listed in the contingent section.
- The sum of the Primary Beneficiary percentages MUST equal 100%. The sum of the Contingent Beneficiary percentages MUST equal 100%. Dollar amounts, fractions and decimals will not be accepted.
- If you need more space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

Please complete the section that pertains to the type of beneficiary you are designating.

☐ **A. Individual Beneficiaries**

PRIMARY BENEFICIARY - Your first choice to receive your life insurance proceeds in the event of your death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name	Middle Initial	Last Name		Share: %
MARY	A	MULLINS		100
Address – Street	City	State	ZIP Code	
904 WELEKA LN.	CARLSBAD	NM	88220	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	
LIFE PARTNER	[redacted]		(575) 706-2740	

First Name	Middle Initial	Last Name		Share: %
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	
			( )	

First Name	Middle Initial	Last Name		Share: %
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	
			( )	

EXHIBIT (A)

CONTINGENT BENEFICIARY - Your second choice to receive your life insurance proceeds if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First Name	Middle Initial	Last Name			Share: %
Address – Street	City		State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ( )		

First Name	Middle Initial	Last Name			Share: %
Address – Street	City		State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ( )		

☐ **B. Living Trust** – ☐ Primary ☐ Contingent

If this form is executed by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.

Trust Name		Trust Date	Trustee Phone Number ( )		Share: %
Trustee - First Name	Middle Initial	Last Name			
Trustee Address – Street	City		State	ZIP Code	

☐ **C. Testamentary Trust Created in the Insured's Will** – ☐ Primary ☐ Contingent

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

Share: %

☐ **D. Insured's Estate** – ☐ Primary ☐ Contingent

If the Insured's Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named.

☐ **E. Charity/Organization** – ☐ Primary ☐ Contingent

Be sure to name the charity or organization and not the charity or organization director or an employee of that charity/organization.

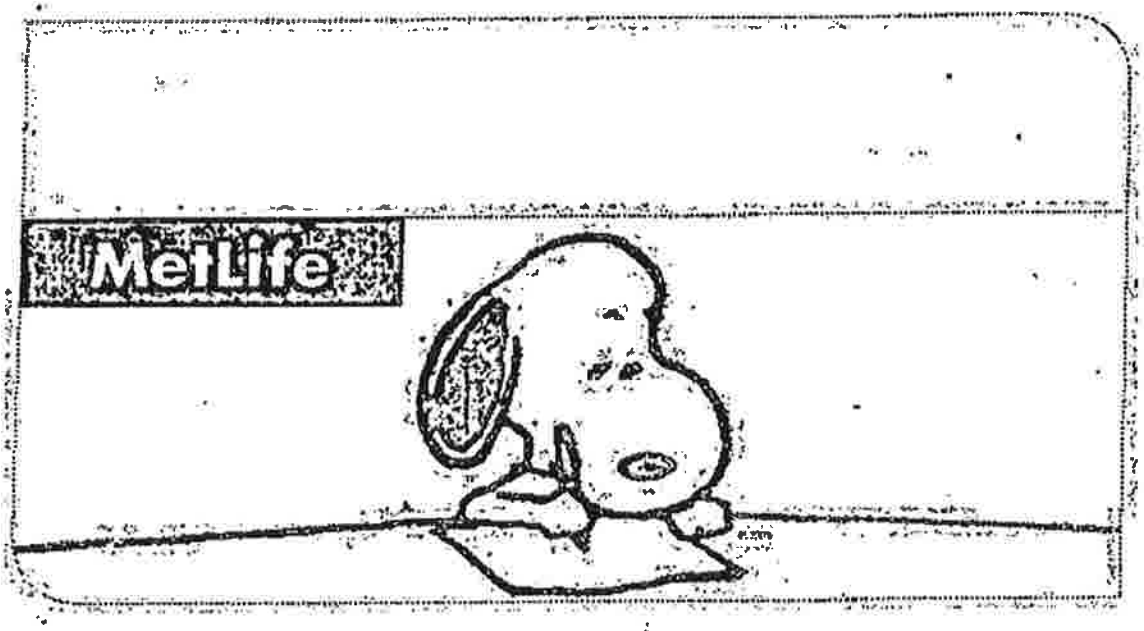
Charity/Organization Name		Phone Number ( )		Share: %
Address – Street	City	State	ZIP Code	

Lexington KY 40512-4590

Royce Allen
904 Weleka Ln
Carlsbad, NM 88220-8833

RP1506156234_1-117794-31

EXHIBIT (B)



WE HAVE RECEIVED YOUR METLIFE LONG TERM DISABILITY (LTD) CLAIM. AS WE BEGIN OUR CLAIM REVIEW WE THOUGHT THIS INFORMATION WOULD HELP YOU.

WHY DOES METLIFE NEED THESE FORMS?
These claim forms help MetLife obtain medical information to make our initial claim decision, get a clear picture of what you can and cannot do today due to your illness/injury, and provide other information needed to administer your employer's plan. If you have specific questions about any of the forms, do not hesitate to contact your Claims Specialist.

WILL I HAVE TO FILL OUT MORE PAPERWORK AFTER I COMPLETE THESE FORMS?
Typically the forms you have received with this packet will be all of the forms we ask you to complete as we work on reaching an initial decision on your LTD claim. Your Claims Specialist will try to limit any additional requests and only ask for what is necessary to make a claim decision. If you ever have a question about what is being requested or why it is being requested, please feel free to reach out to your Claims Specialist for additional clarification.

HOW WILL I KNOW IF SOMETHING ELSE IS NEEDED FROM ME TO MAKE A CLAIM DECISION?
Your Claims Specialist or another claims associate such as a Nurse Consultant or a Vocational Rehabilitation Consultant will call you and/or send you a letter to let you know when information is needed from you or another source such as your Health Care Provider.

HOW WILL I KNOW IF A DECISION IS REACHED?
Your Claims Specialist will call you and send a letter to explain the details of the decision and next steps.

WHAT IF I HAVE A SHORT TERM DISABILITY CLAIM WITH METLIFE?
You may continue to receive calls and/or letters regarding your Short Term Disability (STD) until that claim is no longer payable. Please continue to discuss any questions you have regarding your STD claim with your STD Claims Specialist and send in information pertinent to that claim using the STD claim number.

Please include the claim number on all correspondence with MetLife.

METLIFE CONTACT INFORMATION

Effective communication is a two-way process. We encourage you to call your Claims Specialist anytime you have questions. You should also call if you have information to report such as if you return to work, move, change doctors or start receiving a different amount or type of other income.

PLEASE INCLUDE YOUR CLAIM NUMBER 711506051682 ON EACH PAGE OF CORRESPONDENCE.

PHONE	Claim Specialist's Name Megan Krandel	Office phone # 1-800-638-2242 Direct Extension: 4933
	Customer Service Representative 8am-11pm EST	Office phone # 1-800-638-2242
FAX	1-800-230-9531	
MAIL	Regular	Certified/Overnight
	MetLife Disability PO Box 14590 Lexington KY 40512-4590	MetLife Disability c/o Xerox Commercial Solutions 2025 Leestown Road, Suite A-2 Lexington, KY 40512 Telephone: 859-825-6486 (for overnight deliveries only)

Please include the claim number on all correspondence with MetLife.

Metropolitan Life Insurance Company
MetLife Disability, P O Box 14590, Lexington, KY 40512
Phone: 1-800-638-2242 Fax: 1-800-230-9531

MetLife®

NOT FOR SERVICE OF LEGAL PROCESS

June 15, 2015

Royce Allen
904 Welcka Ln
Carlsbad, NM 88220-8833

Acknowledgement of LTD claim
Employer: NUCLEAR WASTE PARTNERSHIP LLC
Claim #: 711506051682
ID Number:

Dear Mr. Royce Allen:

We are writing to acknowledge the receipt of your Long Term Disability (LTD) claim. We are committed to partnering with you in order to ensure a timely claim decision.

WHAT WE NEED FROM YOU
We need additional information from you to help in making an accurate and timely decision. By promptly completing and returning the forms listed below, you can help the progress of your claim evaluation:

The following information needs to be returned to MetLife:

- Authorizations to disclose information about me
- Reimbursement agreement
- Employee statement
- Personal profile
- Beneficiary designation
- Social Security authorization
- Copy of Social Security award or denial and/or proof of filing
- All medical records including, but not limited to all office visit notes, test results, operative reports and/or hospitalization records, therapy notes and treatment plans from March 26, 2015 and forward from Dr. Marilyn Hines
- Physical Capacity Evaluation form - to be completed by Dr. Hines

The following information is also requested and should be returned if applicable:

- Authorization to be referred to a Social Security law firm

If we have not already completed a detailed interview, please contact me to set up an interview as soon as possible at 1-800-638-2242 4933. Please submit the applicable forms listed above by July 15, 2015. Your authorizations are especially critical as they allow us to gather information from medical providers to complete our evaluation.

Any reasonable cost associated with providing this information is your responsibility.

If you apply for or receive Social Security benefits at any time during the life of your LTD claim, please provide our office with a copy of this information. We have enclosed a list of frequently asked questions (FAQ) related to Social Security for your review. The enclosed FAQ document provides detail on how you can contact the Social Security Administration (SSA).

Please include the claim number on all correspondence with MetLife.

WHAT WILL HAPPEN IF WE DO NOT HEAR FROM YOU
If we do not hear from you by July 15, 2015 there may be a delay in our ability to make a prompt claim decision.

WE ARE HERE TO HELP
If you have questions or need additional information regarding your claim, you can reach me directly at 1-800-638-2242 4933. Our Customer Response Center has extended business hours Monday through Friday from 8:00 A.M. to 11:00 P.M. Eastern Time at 1-800-638-2242 and can assist you with many claim questions if I am unavailable.

Sincerely,

Megan Krandel
MetLife Disability

Enclosures

Please include the claim number on all correspondence with MetLife.

MetLife
Metropolitan Life Insurance Company
P.O. Box 14530
Lexington, KY 40512
Fax: 1-800-230-8531

DISABILITY BENEFICIARY DESIGNATION

Please read instructions on next page before completing this form. Do not erase or attempt to make corrections; use a new form.

Name of Employer NUCLEAR WASTE PARTNERSHIP LLC

Employee's Disability Claim Number 7115D6051682 Employee's Social Security No. [redacted]

I hereby designate the following individual(s) as primary beneficiary(ies) and contingent beneficiary(ies) (if any) in the event of my death during the period in which I am receiving Disability benefits under the claim number above or any associated disability claim. This beneficiary designation will be automatically revoked on the date that my Disability benefits under the claim number above, or any associated disability claim, end.

Primary Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Daytime Phone #	Evening Phone #	Share %
MULLINS, MARY ANN	LIFE PARTNER	[redacted]	575 234-8863	575 887-3781	100
Address (Street, City, State, Zip)			Social Security Number		
904 WELEKA LN., CARLSBAD, NM 88220			[redacted]		
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Daytime Phone #	Evening Phone #	Share %
Address (Street, City, State, Zip)			Social Security Number		
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Daytime Phone #	Evening Phone #	Share %
Address (Street, City, State, Zip)			Social Security Number		
Payment will be made in equal shares to the survivors unless otherwise indicated.			TOTAL:		100%

In the event that said primary beneficiaries predecease me, I designate as contingent beneficiary(ies)

Contingent Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Daytime Phone #	Evening Phone #	Share %
Address (Street, City, State, Zip)			Social Security Number		
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Daytime Phone #	Evening Phone #	Share %
Address (Street, City, State, Zip)			Social Security Number		
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Daytime Phone #	Evening Phone #	Share %
Address (Street, City, State, Zip)			Social Security Number		
Payment will be made in equal shares to the survivors unless otherwise indicated.			TOTAL:		100%

If no beneficiary or contingent beneficiary designated shall be living following my death, the amount payable by reason of my death shall be payable as provided by the applicable Disability Income Insurance Plan ("Plan").

Note: See Next Page for Important Information

☐ **Trust(ee) Designation** (applies only if a trust has been created in an executed trust agreement)

Name of Trustee(s) _____

Address _____ City _____ State _____ Zip Code _____

and successor(s) in trust, as Trustee(s) under _____
("Title of Agreement")

Dated _____ executed by me and said Trustee(s).

MetLife shall not be responsible for the application or disposition of the proceeds by said Trustee(s), and the receipt of the proceeds by said Trustee(s) shall be full discharge of the liability of MetLife under the Plan.

It is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at my death, the beneficiary shall be My Estate, and payment to my legal representative based on such proof shall be full discharge of liability of MetLife under the Plan or certificate.

☐ **Trust(ee) (Under Will) Designation** (applies only if a trust has been set forth in your Will)

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate My Estate as beneficiary and any payment made in good faith to the legal representative of my estate shall be full discharge of the liability of MetLife under the Group Policy.

I reserve the right to change the designated beneficiary(ies) at any time without (his/her/their) consent.

(Please Print)

ROYCE E. ALLEN — Name of Insured

575-887-3787 — Daytime Phone No.

904 WELEKA LN., CARLSBAD, NM 88220 — Street Address / City / State / Zip Code

Royce E Allen — Signature of Insured

Aug 22, 2015 — Date Signed

Submit Completed Form to MetLife and Retain a Copy for Your Records

GENERAL BENEFICIARY INFORMATION

You may find the following definitions helpful in completing your Beneficiary Designation form.

Primary Beneficiary: Your primary beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds. You may have the proceeds divided among several primary beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Contingent Beneficiary: Your contingent beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds if your primary beneficiary(ies) (see definition above) predecease(s) the insured. You may have the proceeds divided among several contingent beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Trust(ee) Designation: If you plan to have the insurance proceeds distributed through a Trust, you should complete this section with the appropriate information. Your Trust(ee) will be held fully responsible for the application for and disposition of the insurance proceeds. **This section should only be used if you have a legally drawn inter vivos trust agreement or an appropriate Trust(ee) is designated under your Last Will and Testament. If you complete this section, do NOT complete the Primary or Contingent Beneficiary sections.**

An inter vivos trust is a trust established during the life of the trustor (the person who creates the trust) for the benefit of the trustor or other living persons.

INSTRUCTIONS FOR COMPLETING BENEFICIARY DESIGNATION

1. Fill in the insured's Name of Employer, Disability claim number and Social Security Number at the top of the form. At the bottom of the form, fill in the name of the insured person or owner (if assigned), the daytime phone number, address, and sign and date the form.
2. Fill in the Primary Beneficiary(ies) and Contingent Beneficiary(ies), if any. For each Primary and Contingent Beneficiary listed, enter the relationship (when the relationship of the beneficiary is other than by blood or marriage, the relationship should be shown as "Nonrelative"), date of birth, address(es) (permanent residence), daytime and evening phone numbers, Social Security Number and percentage of share (all shares must add up to 100%).
3. If you wish to name a Trust(ee) as beneficiary, complete one of the two Trust(ee) Designations instead of the Primary and Contingent Beneficiary sections. If the trust is an inter vivos trust, check only the first Trust(ee) Designation box, and complete the top Trust(ee) designation. You should enter (1) the name and address of the Trust(ee); (2) the Title of the Agreement; and (3) the date of its execution. **NOTE: AN INTER VIVOS TRUST MUST BE A LEGALLY DRAWN AGREEMENT.**

If you wish to make a Trust(ee) under Will Designation, check only the second Trust(ee) Designation box. **NOTE: A TRUST(EE) UNDER WILL (OR TESTAMENTARY TRUST(EE) MUST BE ESTABLISHED UNDER THE LEGALLY DRAWN LAST WILL AND TESTAMENT OF THE INSURED OR OWNER (IF ASSIGNED).**

4. You, the owner of the coverage should sign and date the form in the spaces provided. Retain a copy for your records.
5. Fax or mail the completed form to the number or address provided on page 1.

If you wish to name more beneficiaries than this form provides for, secure an additional copy. Complete your list of beneficiaries on that form. Attach the additional form to the first, indicating clearly on each form the number of additional forms attached. For example, if three forms are used, number the forms as follows: 1 of 3, 2 of 3 and 3 of 3.

It is important that you review your beneficiary designation periodically to ensure that the beneficiary information you supplied is up to date.

You may change or revoke your beneficiary designation at any time by completing a new Beneficiary Designation form.

This Beneficiary Designation is pertinent to the Disability claim specified, and is automatically revoked on the date that your Disability benefits, under the claim number above, or any associated disability claim, end.

LONG TERM DISABILITY CLAIM FORM EMPLOYEE STATEMENT

MetLife®
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

Instructions for completing the claim form:
1. Complete all applicable areas of the claim form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign the claim form.
4. Fax this form to expedite your claim – retain original for your records.
5. *Contact MetLife at 888-444-1433 for any questions you have on completing this form.

Section 1: Personal Information

Name (Last, First, MI) – MUST ANSWER	Employer – MUST ANSWER	Group Report #	ID Number
ALEN, ROYCE E	NWP		

Address / City / State / Zip Code	Date of Birth (MM/DD/YY)	Sex	Social Security #
904 W ELEKA LN, CARLSBAD, NM 88220	[redacted]	☑ M ☐ F	[redacted]

Home Phone #	Work Phone #	Occupation	Marital Status	Tax Exemptions
575-887-3781	575-234-8463	MGR. CONSTRUCTION	☐ Married ☑ Single ☐ Other	1

Dependent Information:

	Name	Date of Birth	SS#
Spouse			
Children			

Section 2: Claim Information

Is your disability due to ☐ Injury/Accident? ☑ Illness?	If due to injury/accident, give date, time and details.
Is this condition work related? ☐ Yes ☑ No	(When, Where, How)

Date of first treatment for this condition	Date Last Worked MUST ANSWER	Date Disability Began	Height	Weight
4/19/15		1/29-9/2 3rd to present	5' 11"	160

Name, address, phone number of your primary attending physician.
DR. DONALD QUECK 4101 22ND PLACE LUBBOCK, TX 79410 806-7259965

Name of physicians/providers who have treated you within the past 2 years.

Name of Physician/Provider	Phone Number	Dates of Treatment	Reason for Visit
See attached list		From To	
		From To	
		From To	

Has the patient been hospitalized? ☐ Yes ☐ No If Yes, give dates from _____ to _____ ☐ Inpatient ☐ Outpatient
Name and address of hospital

Circle Highest Education Level Completed.
1 2 3 4 5 6 7 8 9 10 11 (12) 13 14 15 16 17 18

Degrees, Certificates, License/Skills or training obtained

Please describe what prevents you from performing the duties of your job.
CHEMOTHERERY SIDE AFFECTS / IMMUNE SYSTEM DEPLETED

Have you applied for or are you receiving income from any other sources? ☐ Yes ☐ No
If yes, provide the following information.

	Applied for	Receiving	$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	☐	☑	FULL SALARY	MONTHLY	TO: 9/1/2015
Short Term Disability	☐	☐			
Worker's Compensation	☐	☐			
State Disability	☐	☐			
Social Security	☐	☐			
Dependent Social Security	☐	☐			
No Fault (Income Replacement)	☐	☐			
Retirement/Pension	☐	☐			
Permanent Total Disability	☐	☐			
Other (Please Identify)	☐	☐			

ALLEN, Royce E. [redacted] 911506051682

Name: (Last, First, Middle Initial) Social Security # Report # Claim #

Agreement To Reimburse Overpayment of Long Term Disability Benefits

I, Royce E. ALLEN acknowledge that, if my disability claim is or has been approved, under my Long Term Disability coverage, Metropolitan Life Insurance Company (MetLife) is authorized to reduce the benefits otherwise payable to me by certain amounts paid or payable to me under disability or retirement provisions of the Social Security Act (including any payments for my eligible dependents), under a Worker's Compensation or any Occupational Disease Act or Law, and under any State Compulsory Disability Benefit Law, or any other act or law of like intent.

I understand that, if my disability claim is or has been approved, MetLife is willing to make advance monthly disability payments to me, which because of amounts paid or payable under the laws described above may be in excess of the benefits actually due to me. However, I also understand and accept that MetLife will make these payments, only if, I make certain statements which I represent and warrant to be true and only if I agree as follows:

1. I have not received and am not receiving any payments under the laws described above, whether in the form of benefit payment or a compromise settlement.
2. If I have not already applied for Social Security benefits, then I agree to do so as specified in my Plan of Benefits after I have received my first monthly benefit check from MetLife. As proof of this, I agree to send to MetLife a copy of the Receipt of Claim Form given to me by the Social Security Administration at the time of my application.
3. I agree to file for Reconsideration or Appeal to Social Security if Social Security denies my claim for benefits as specified in my Plan of Benefits.
4. As specified in my Plan of Benefits, when I, my spouse or my dependents receive any disability or retirement payments under the laws described above resulting from my disability, I agree to notify MetLife immediately by sending a copy of the award, notification or check to MetLife.
5. After MetLife has recalculated my monthly benefit payment and has determined the amount of the overpayment, as specified in my Plan of Benefits, I agree to repay to MetLife any and all such amounts which MetLife or employer has advanced to me in reliance upon this Agreement.
6. If for any reason MetLife or employer is not repaid, then I understand that MetLife may reduce my monthly benefit below the minimum monthly benefit amount as stated in my Plan of Benefits, until the overpayment is reimbursed in full.
7. I agree to repay MetLife in a single lump sum any overpayment on my Long Term Disability claim due to integration of retroactive Social Security Benefits.

I understand that when MetLife issues an advance, it is relying on my statements and agreements herein. My acceptance of an advance, along with my signature below, is my acceptance of terms of this Agreement.

Witness Signature 8/22/15 Date Claimant's Signature Royce E. Allen 8/22/15 Date

EES STD 5223 (03/15) Fs

MetLife
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NOTE TO ALL HEALTH CARE PROVIDERS: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Instructions for completing the form:
1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

Royce E Allen — Name of Employee (Please Print)

12/28/1950 — Date of Birth

Claim Number: 211506051682

ID Number:

Authorization to Disclose Information About Me

For purposes of determining my eligibility for disability benefits, the administration of my employer's disability benefit plan (which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, including but not limited to any workers compensation, employee assistance or disease management program, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. I permit any physician or other medical/care provider, hospital, clinic, other medical related facility or service, pharmacy benefit administrator, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and disability claim.
2. I permit MetLife to disclose to my employer or its agents acting in the capacity of administrator of its benefit plans or programs, including but not limited to, workers compensation, employee assistence, or disease management programs, any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me specifically includes my permiss or to disclose my entire medical record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. Infonmation concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnessos may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as pumitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

I understand that I may revoke this authorization at anytime by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40512-4590, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

Royce E Allen — Signature of Employee

8/22/15 — Date

Disability Claim Employee Statement (Continued)

Fraud Warning:

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona – For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

California – For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma – WARNING: Any person who knowingly and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky – Any person who knowingly and with the intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire – A person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon and Vermont – Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.